

**ADAD-PN3 Authorization for Use or Disclosure of Medical Information****Read this information first**

You should complete this form if you wish to authorize us to use or disclose your medical information to persons who are not directly involved in making decisions regarding your health care. This authorization remains in effect until the date you specify or the date you revoke it.

Note We allow you to call us and give a verbal agreement over the telephone to disclose your medical information to persons who are directly involved in making decisions regarding your health care. To do so, please call **1 800 624-2459** (8 a.m. to 5 p.m. weekdays) or **1 800 544-5304** our TDD (telecommunications device for the deaf).

Mail this form to: Pharmaceutical Assistance Section, Illinois Department of Revenue, P.O. Box 19021, Springfield, IL 62794-9021.

Step 1: Complete the participant's or applicant's information

1 _____
Participant's or applicant's name

2

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Participant's or applicant's SSN

Step 2: Tell us what medical information may be used or disclosed

3 Check the appropriate box to indicate what information may be used or disclosed.

a My entire record. ☐

b Other (specify) _____ ☐

4 Check the appropriate box to indicate the purpose of the use or disclosure.

a At my request. ☐

b Other (specify) _____ ☐

Step 3: Tell us who you are authorizing to use or receive your medical information

5 _____
Name of authorized person

Address of authorized person

City State ZIP

Phone

6 _____
Name of authorized person

Address of authorized person

City State ZIP

Phone

7 _____
Name of authorized person

Address of authorized person

City State ZIP

Phone

8 _____
Name of authorized person

Address of authorized person

City State ZIP

Phone

Note Optional: authorization termination date: ____ / ____ / ____
Month Day Year

Step 4: Complete your acknowledgment**I understand and acknowledge that:**

- I have received a copy of Form ADAD-PN, Pharmaceutical Assistance Program Privacy Notice;
- I do not have to complete this authorization and my refusal will not affect my prescription coverage unless the authorization is necessary to determine my eligibility for benefits;
- The information used or disclosed by this authorization may be at risk for redisclosure by the recipient and no longer protected by federal privacy laws;
- I have a right to revoke this authorization at any time by completing and sending to the department, Form ADAD-PN4, "Revocation of Authorization" (except to the extent that action has already been taken in reliance on this authorization); and
- If the department seeks an authorization from me for use or disclosure of my medical information, the department will provide me with a copy of the signed authorization.

9 _____
Participant's, applicant's, or personal representative's signature

____ / ____ / ____
Month Day Year

10 _____
Personal representative's relationship to participant or applicant